

TRUST BOARD PART I – MAY 2012

Agenda Item Number: 74/12  
Enclosure Number: (6)

<b>Subject:</b>	Assurance Framework
<b>Prepared by:</b> <b>Sponsored by:</b> <b>Presented by:</b>	Sheena King – Head of Risk Management Peter Mellor – Company Secretary Peter Mellor – Company Secretary
<b>Purpose of paper</b>  <i>Why is this paper going to the Trust Board?</i>	Requires Trust Board guidance Discussion requested by Trust Board Regular Reporting Statutory Requirement
<b>Key points for Trust Board members</b>  <i>Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals</i>	Trust Board are asked to note <ul style="list-style-type: none"> <li>• Top risks</li> <li>• New Risks 3.1, 3.2, 3.3, 3.4, 4.1, 4.2</li> <li>• Re-described risks for 2012/13 – 2.1, 5.1, 5.2, 5.3, 6.1, 6.2, 6.3</li> </ul>
<b>Options and decisions required</b>  <i>Clearly identify options that are to be considered and any decisions required</i>	<ul style="list-style-type: none"> <li>• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks.</li> <li>• Determine any further assurance required on any aspect of the Framework</li> </ul>
<b>Next steps / future actions:</b>  <i>Clearly identify what will follow the Trust Board's discussion</i>	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented to Trust Board in June 12.
<b>Consideration of legal issues (including Equality Impact Assessment)?</b>	None
<b>Consideration of Public and Patient Involvement and Communications Implications?</b>	None

**ASSURANCE FRAMEWORK REPORT**

**TRUST BOARD: May 2012**

**Purpose:**

To provide the Trust Board with an update on the Assurance Framework as of 22 May 2012

**Top Risks**

**4.1 (Red 16):** Future workforce demand requirements are unable to be met due to the reducing size of the labour pool available resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels

**New Risks**

- 3.1 (Amber 12):** Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust
- 3.2 (Amber 12):** Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities
- 3.3 (Amber 12):** Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities
- 3.4 (Amber 12):** Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change.
- 4.1 (Red 16):** Future workforce demand requirements are unable to be met due to the reducing size of the labour pool available resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels
- 4.2 (Amber 12):** Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.

**Risks with an Increased Score**

Nil

**Risks with a Decreased Score**

Nil

**Re-described risks for 2012/13**

- 2.1 (Amber 9):** Failure to improve results of the national Inpatient survey by 2 points as required by CQUIN results in financial penalty up to £436,500
- 5.1 (Amber 9):** The Trust breaches emergency department quality standards key targets – ED Patient Impact, ED Timeliness
- 5.2 (Yellow 6):** The Trust fails to achieve the required referral to treatment targets for admitted patients at a specialty level and reduce the 18 week admitted backlog
- 5.3 (Yellow 6):** The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit
- 6.1 (Amber 12):** The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners
- 6.2 (Amber 12):** 2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position
- 6.3 (Amber 12):** The Trust's need to deliver £27m of savings in 2012/13 has a detrimental impact on the quality of services provided to patients.

**Target Date Changes**

Nil

**Prepared by:** Sheena King – Head of Risk Management & Legal Services

**Presented by:** Peter Mellor – Company Secretary

ASSURANCE FRAMEWORK 2012/13 – PROGRESS SUMMARY – MAY 2012

STRATEGIC AIM Executive Lead	OPERATIONAL LEAD RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	CQC OUTCOME REFERENCE	PROGRESS MONTH ON MONTH												TARGET (RESIDUAL) RISK SCORE/DATE TO ACHIEVE	
				JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
1. To provide best care as measured by clinical effectiveness, safety and patient experience (JD/SH)	FMcN (G&C)	1.2 Inability to maintain ongoing compliance with all CQC standards	8	12	12	9	9	9									6 Jun 12
2. To be the hospital of choice for patients (JD/SH)	SB (SPSSG)	2.1 Failure to improve results of the national Inpatient survey by 2 points as required by CQUIN results in financial penalty up to £436,500	ALL					9									3 Feb 13
3. To achieve our strategic aims, through living our values and through the skills and personal development of our staff (TP)	TP	3.1 Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust	14					12									8 Mar 13
	TP	3.2 Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities	14					12									8 Oct 12
	TP	3.3 Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities.	14					12									6 Oct 12
	TP	3.4 Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change.	14					12									8 Dec 12
4. To be the employer of choice in South East Hampshire (TP)	TS (SMT)	4.1 Future workforce demand requirements are unable to be met due to the reducing size of the labour pool available resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels	13					16									8 Oct 12
	TP (SMT)	4.2 Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.	13					12									6 Jan 13
5. Be in the top quartile of NHS hospitals for 95% of all services we provide (CW)	CW (SMT)	5.1 The Trust breaches emergency department quality standards key targets – ED Patient Impact, ED Timeliness	4					9									3 Jun 12
	CW (SMT)	5.2 The Trust fails to achieve the required referral to treatment targets for admitted patients at a specialty level and reduce the 18 week admitted backlog	4					6									3 Jun 12

STRATEGIC AIM Executive Lead	OPERATIONAL LEAD RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)		CQC OUTCOME REFERENCE	PROGRESS MONTH ON MONTH												TARGET (RESIDUAL) RISK SCORE/DATE TO ACHIEVE
					JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
	CW (SMT)	5.3	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	4					6								3 Jun 12
6. Work with our partners to create a sustainable economic enterprise, which eliminates waste and provides real value for money (RT)	SG (FC)	6.1	The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners	26					12								8 Mar 13
	SG (FC)	6.2	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	26					12								8 Mar 13
	SG (FC)	6.3	The Trust's need to deliver £27m of savings in 2012/13 has a detrimental impact on the quality of services provided to patients.	26					12								8 Mar 13

**STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE**

Responsible Executive: Director of Nursing/Medical Director

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress	
REF. NO (CQC Ref)	RISK DESCRIPTION  (Obstacle to achievement of Strategic Aim)	KEY CONTROLS  Any specific measures currently in place to control the risk.	POSITIVE (ACTUAL) SOURCES OF ASSURANCE Evidence that shows risks are being reasonably managed	INITIAL RISK RATING (C x L)	CURRENT RISK RATING (C x L)	PREDICTED (RESIDUAL) RISK	GAPS IN CONTROLS The identification of any failure to establish effective Controls.	GAPS IN ASSURANCE The identification of any failure to gain evidence relating to the effectiveness of the Controls.	ACTION PLAN Details of actions to address identified gaps in either Controls or Assurance		On target	
									Plan GC – Gap in Controls GA – Gap in Assurance		Minor obstacle to achieving target	
1.2 (All)	Inability to maintain ongoing compliance with all CQC standards	<ul style="list-style-type: none"> <li>Quarterly CSC self-assessment + compliance statements</li> <li>Outcome Leads</li> <li>NHSLA Level 1 accreditation (Mar 12)</li> <li>Accepted for CQC registration without conditions 2010/11</li> <li>CSC risk registers</li> <li>Mock CSC assessments and associated action plans</li> <li>Monitor Quality Risk Profile monthly</li> <li>Quarterly evidence and action plan review panels established including NED</li> <li>CQC awareness sessions</li> <li>Action plan to address minor concerns for ongoing compliance with outcomes 4, 5 and 21</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly compliance to TB and key committees + monthly exception reporting (action plans in place for any identified compliance issues)</li> <li>Clinical dashboards / quality metrics</li> <li>CSC governance reports</li> <li>Mock CSC assessments</li> <li>Outcome of second quarterly evidence review panels show continued improvement in outcome focused evidence</li> <li>Internal CQC audit (Deloitte) Apr 11, demonstrating substantial assurance.</li> <li>Compliance audits</li> </ul>	12 (3x4) FMcN G&Q	9 (3x3)	6 (3x2)	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Follow-up responsive review on 3<sup>rd</sup> and 4<sup>th</sup> January.</li> <li>Final report received: compliant with outcomes 1 and 9, minor concerns with outcomes 4 and 5 and moderate concern with outcome 21. Action plans submitted to CQC.</li> <li>No further correspondence from CQC. Action plan presented to Governance &amp; Quality Committee 03 April</li> </ul>	For ongoing monitoring until all actions complete – Action plan complete.  GA: action plan to be monitored monthly by Governance and Quality Committee	Mar-12 Jun 12 Ongoing	Review Feb-12 Jun 12	

**STRATEGIC AIM 2: TO BE THE HOSPITAL OF CHOICE FOR PATIENTS**

Responsible Executive: Director of Nursing/Medical Director

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
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									Plan GC – Gap in Controls GA – Gap in Assurance	Minor obstacle to achieving target	Inability to achieve predicted target
2.1 (16)	Failure to improve results of the national Inpatient survey by 2 points as required by CQUIN results in financial penalty up to £436,500	<ul style="list-style-type: none"> <li>Trust wide action plan</li> <li>Quality Improvement Group</li> <li>New 5 key questions survey</li> <li>CSC targets for patient participation in survey – subject to performance review</li> <li>Monitored by Income Protection Group</li> </ul>	<ul style="list-style-type: none"> <li>Optimum real time patient survey</li> </ul>	9 (3x3)	9 (3x3)	3 (3x1)	<ul style="list-style-type: none"> <li>CSCs need to achieve increasing patient participation targets</li> </ul>	<ul style="list-style-type: none"> <li>No reports available at present</li> </ul>	GC: leads for 5 key questions to be identified in each CSC and undertake patient surveys to achieve target GA: real time reports to be analysed and presented to PESG and Income protection Group monthly	Jun 12	Feb 13

**STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF**

**Responsible Executive: Chief Operating Officer**

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress	
REF. NO (CQC Ref)	RISK DESCRIPTION  (Obstacle to achievement of Strategic Aim)	KEY CONTROLS  Any specific measures currently in place to control the risk.	POSITIVE (ACTUAL) SOURCES OF ASSURANCE  Evidence that shows risks are being reasonably managed	INITIAL RISK RATING (C x L)	CURRENT RISK RATING (C X L)	PREDICTED (RESIDUAL) RISK	GAPS IN CONTROLS  The identification of any failure to establish effective Controls.	GAPS IN ASSURANCE  The identification of any failure to gain evidence relating to the effectiveness of the Controls.	ACTION PLAN  Details of actions to address identified gaps in either Controls or Assurance		On target	
									Plan GC – Gap in Controls GA – Gap in Assurance		Minor obstacle to achieving target	
3.1 (14)	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust.	<ul style="list-style-type: none"> <li>Training plans developed to reflect CSC strategic priorities.</li> <li>Membership of the shadow Local Education and Training Board.</li> <li>Evaluation of learning outcomes undertaken.</li> </ul>	<ul style="list-style-type: none"> <li>Strategic Education Board in place.</li> <li>Trainee feedback in relation to programmes positive (national Staff Survey, post graduate training feedback).</li> </ul>	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> <li>Learning and education strategy is defined at a high level but requires greater detail.</li> <li>Director of Medical Education is retiring in June 2012.</li> </ul>	<ul style="list-style-type: none"> <li>There is no evaluation process in place to identify the link between learning and education programmes and patient outcomes.</li> </ul>	GC - Director of Medical Education post to be filled.  GC - Strategic education board to define future learning strategy and monitor outcomes.  GA – development and deployment of the education outcomes framework.	Jul 12  Oct 12  Mar 13	Review Mar 13	
3.2 (14)	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities.	<ul style="list-style-type: none"> <li>Performance assurance framework trials for CSCs commenced</li> <li>SHA funded performance appraisal project for consultants introduced</li> </ul>	<ul style="list-style-type: none"> <li>85% compliance with appraisal completions</li> <li>Significant improvement to staff survey results for effectiveness of appraisal</li> <li>Performance assurance project board established.</li> </ul>	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> <li>Variation in performance at CSC and individual level.</li> <li>Consequence management framework not established.</li> </ul>	<ul style="list-style-type: none"> <li>Appraisal performance measures currently only look at compliance with no individual rating scale evident.</li> </ul>	GC – Performance assurance framework deployed across all CSCs GC / GA – review of performance appraisal process to introduce ratings and consequence management frameworks.	Aug 12  Sep 12	Review Oct 12	
3.3 (14)	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities.	<ul style="list-style-type: none"> <li>Staff survey action plans developed within CSCs</li> <li>Health and well-being programme established.</li> <li>Employee recognition programmes in place.</li> </ul>	<ul style="list-style-type: none"> <li>Improved performance in 2011 national staff survey results.</li> <li>Lower than average levels of sick absence and staff turnover.</li> </ul>	12 (3x4)	12 (3x4)	6 (3x2)	<ul style="list-style-type: none"> <li>Staff survey results still show lower than acceptable scores against some key findings.</li> </ul>	<ul style="list-style-type: none"> <li>Staff concerns or issues not captured sufficiently well enough with little Board visibility of underlying themes.</li> </ul>	GC – bottom up action plans to be developed by CSCs. GA – review of internal communication process including team-brief. GA – regular reporting to Board on staff issues.	Jun 12  Sep 12  Jul 12	Review Oct 12	

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF												
Responsible Executive: Chief Operating Officer												
RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress	
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3.4 (14)	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change.	<ul style="list-style-type: none"> <li>Leadership development programmes in place to support leaders at various levels.</li> </ul>	<ul style="list-style-type: none"> <li>Utilisation of existing leadership development programmes.</li> <li>SHA funded projects in development including team based working.</li> </ul>	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> <li>Expectations of leaders not clearly defined.</li> </ul>	<ul style="list-style-type: none"> <li>There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.</li> </ul>	GC – development of a Trust wide leadership brand. GA – development of talent management process to capture potential future leaders GA – review the range of leadership development opportunities currently offered. GA – use of Leadership Framework 360 and self assessment tool to identify development needs at Trust and individual level	Aug 12 Oct 12 Oct 12 Oct 12	Review Dec 12	



**STRATEGIC AIM 4: TO BE THE EMPLOYER OF CHOICE IN SOUTH EAST HAMPSHIRE**  
Responsible Executive: Director of Human Resources

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
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									Plan GC – Gap in Controls GA – Gap in Assurance	Minor obstacle to achieving target	Inability to achieve predicted target
4.1 (13)	Future workforce demand requirements are unable to be met due to the reducing size of the labour pool available resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels.	<ul style="list-style-type: none"> <li>Corporate CIP plan developed to reduce temporary staffing levels.</li> <li>Review of recruitment processes for Nursing cohort undertaken</li> <li>Workforce Strategy Committee ensures critical posts are resourced.</li> </ul>	<ul style="list-style-type: none"> <li>Business planning process has identified resource requirements for CSC service delivery.</li> <li>WSC process reviewed to ensure critical posts are prioritised for recruitment</li> </ul>	16 (4x4)	16 (4x4)	8 (4x2)	<ul style="list-style-type: none"> <li>Ineffective workforce planning at CSC level.</li> <li>High levels of temporary resource currently in place.</li> <li>Reduction in Junior Doctor resource will increase demand for consultants in some specialities.</li> <li>Attraction strategy is poorly defined.</li> </ul>	<ul style="list-style-type: none"> <li>Reporting of workforce metrics does not facilitate early decision making.</li> </ul>	GC – Workforce planning tool to be developed to enable more effective resource plans to be developed in CSCs. GC – Temporary workforce control panel to be introduced GC – Speciality specific attraction strategies to be developed for CSCs in difficult to recruit areas. GA – full deployment of e-rostering system.	Aug 12  Jun 12  Aug 12  Sep 12	Review Oct 12
4.2 (13)	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.	<ul style="list-style-type: none"> <li>Definition of critical posts established and used by WSC to prioritise recruitment.</li> </ul>	<ul style="list-style-type: none"> <li>Remaining GM posts in process of being filled.</li> </ul>	12 (3x4)	12 (3x4)	6 (3x2)	<ul style="list-style-type: none"> <li>Performance appraisal does not capture career progression potential.</li> <li>Process for defining and identifying those with potential is not established.</li> <li>Critical posts have not been reviewed to ensure the highest return on investment.</li> </ul>	<ul style="list-style-type: none"> <li>Talent is not reviewed at senior management level or at CSC level.</li> <li>Succession plans are not evident across the Trust</li> </ul>	GC – review of appraisal process for Band 7 and above. GC – talent review process to be developed and linked to appraisal. GA – Talent review meetings to take place at Board and CSC levels GA – Succession plans at senior management level to be developed	Sep 12  Oct 12  Nov 12  Nov 12	Review Jan13

**STRATEGIC AIM 5: TO BE IN THE TOP QUARTILE OF NHS HOSPITALS FOR 95% OF ALL THE SERVICES WE PROVIDE**

**Responsible Executive: Chief Operating Officer**

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE	ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress	
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									Plan GC – Gap in Controls GA – Gap in Assurance		On target
5.1 (4)	The Trust breaches emergency department quality standards key targets – ED Patient Impact ED Timeliness	<ul style="list-style-type: none"> <li>Key performance indicators</li> <li>Patient flow project</li> <li>Common pathway developed for all patients to achieve rapid assessment and start of treatment</li> </ul>	<ul style="list-style-type: none"> <li>Monthly COO's Operational Performance Report</li> </ul>	9 3x3	9 (3x3)	3 3x1	<ul style="list-style-type: none"> <li>Demand continues to increase over forecast activity levels (9% above predicted in 2011/12)</li> </ul>	<ul style="list-style-type: none"> <li>Monthly COO's Operational Performance Report</li> </ul>	GA: undertake further audit and monitoring of unscheduled returns in both majors and minors  GC: Implement PHT care pathway recovery and improvement action plans to support capacity, processes and workforce alignment.	May 12 Completed  Jun 12	Review Jun 12
5.2 (4)	The Trust fails to achieve the required referral to treatment targets for admitted patients at a specialty level and reduce the 18 week admitted backlog.	<ul style="list-style-type: none"> <li>Key performance indicators</li> <li>Clinically urgent patients managed in order of clinical priority</li> <li>Breach of target in four specialties to reduce backlog agreed with commissioners</li> </ul>	<ul style="list-style-type: none"> <li>Monthly COO's Operational Performance</li> </ul>	9 3x3	6 3x2	3 3x1	<ul style="list-style-type: none"> <li>18 week backlog in key specialties impacting on aggregate 95<sup>th</sup> percentile</li> </ul>	<ul style="list-style-type: none"> <li>Monthly COO's Operational Performance Report</li> </ul>	GC/GA: activity plan and trajectory in place to clear the admitted backlog in key specialties, and monitored	Jun 12	Review Jun 12
5.3 (4)	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	<ul style="list-style-type: none"> <li>Key performance indicators</li> <li>Breach tracking</li> <li>Agreement with ambulance trust to pre-alert PHT of patient on their way to ED</li> <li>Escalation process in place for breaches by ambulance Trust</li> </ul>	<ul style="list-style-type: none"> <li>Monthly COO's Operational Performance Report</li> </ul>	9 3x3	6 3x2	3 3x1	<ul style="list-style-type: none"> <li>Not all patients are directly admitted to Stroke Unit</li> </ul>	<ul style="list-style-type: none"> <li>Monthly COO's Operational Performance Report (shows 87% direct admission, target 90%)</li> </ul>	GC/GA: Dedicated Stroke Co-ordination Nurse Team appointed in April 2012	May 12	Review Jun 12

STRATEGIC AIM 6: WORK WITH OUR PARTNERS TO CREATE A SUSTAINABLE, ECONOMIC ENTERPRISE, WHICH ELIMINATES WASTE AND PROVIDES REAL VALUE FOR MONEY												
Responsible Executive: Director of Finance												
RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress	
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									Plan GC – Gap in Controls GA – Gap in Assurance		Minor obstacle to achieving target	
Inability to achieve predicted target												
6.1 (26)	The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners.	<ul style="list-style-type: none"> <li>Monthly contract monitoring reports</li> <li>Monthly contract review meetings</li> <li>Income Protection Group</li> <li>Monthly CSC performance meetings</li> </ul>	<ul style="list-style-type: none"> <li>Monthly contract monitoring reports</li> </ul>	12 (4x3) SG FC	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> <li>Current monthly reports do not adequately expose the financial risk (especially at CSC level).</li> </ul>	<ul style="list-style-type: none"> <li>Current monthly reports do not adequately expose the financial risk (especially at CSC level).</li> </ul>	GC/GA: Monthly reports to be revised to ensure they meet requirements		Jul 12	Mar 13
6.2 (26)	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	<ul style="list-style-type: none"> <li>Review of savings performance at Transformation and Finance Committees</li> <li>Monthly CSC performance meetings</li> <li>PMO tracker providing clear information on which initiatives are 'off-track'</li> <li>Defined CSC reporting arrangements</li> </ul>	<ul style="list-style-type: none"> <li>Monthly reporting to Transformation and Finance Committees</li> </ul>	12 (4x3) SG FC	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> <li>Need to develop clear detailed project plans for each of the savings schemes</li> <li>Need to identify project leads for each of the savings schemes</li> </ul>	<ul style="list-style-type: none"> <li>Project plans incomplete – under continuous development</li> </ul>	GC/GA: Project plans and leads currently being finalised		Jun 12	Mar 13

**STRATEGIC AIM 6: WORK WITH OUR PARTNERS TO CREATE A SUSTAINABLE, ECONOMIC ENTERPRISE, WHICH ELIMINATES WASTE AND PROVIDES REAL VALUE FOR MONEY**  
**Responsible Executive: Director of Finance**

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING		Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	RISK DESCRIPTION  (Obstacle to achievement of Strategic Aim)	KEY CONTROLS  Any specific measures currently in place to control the risk.	POSITIVE (ACTUAL) SOURCES OF ASSURANCE  Evidence that shows risks are being reasonably managed	INITIAL RISK RATING (C x L)	CURRENT RISK RATING (C x L)	PREDICTED (RESIDUAL) RISK	GAPS IN CONTROLS  The identification of any failure to establish effective Controls.	GAPS IN ASSURANCE  The identification of any failure to gain evidence relating to the effectiveness of the Controls.	ACTION PLAN  Details of actions to address identified gaps in either Controls or Assurance		On target	
									Plan GC – Gap in Controls GA – Gap in Assurance		Minor obstacle to achieving target	Inability to achieve predicted target
6.3 (26)	The Trust's need to deliver £27m of savings in 2012/13 has a detrimental impact on the quality of services provided to patients.	<ul style="list-style-type: none"> <li>Quality Assurance of plans by CSC management teams</li> <li>Review of savings plans at Transformation and finance committees</li> <li>All savings plans to be signed off by Directors of Medicine and Nursing.</li> </ul>	<ul style="list-style-type: none"> <li>None available yet</li> </ul>	12 (4x3)  SG FC	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> <li>All risk assessments to be completed and savings plans signed off</li> </ul>	<ul style="list-style-type: none"> <li>All risk assessments to be completed and savings plans signed off</li> </ul>	GC/GA: complete risk assessments and savings plans		Jul 12	Mar 13

LEADS		COMMITTEE/GROUP ABBREVIATIONS		OTHER ABBREVIATIONS	
SB	Sarah Balchin	BI	Business Intelligence	CEO	Chief Executive Officer
JD	Julie Dawes	CQRM	Clinical Quality Review Meeting	CHOC	Combined Haematology Oncology Centre
SG	Steve Gooch	CSC	Clinical Service Centre	COO	Chief Operating Officer
SH	Simon Holmes	EMT	Executive Management Team	CoS	Chief of Service
FM	Fiona McNeight	FC	Finance Committee	CQC	Care Quality Commission
TP	Tim Powell	G&Q	Governance & Quality Committee	CQUIN	Commissioning for Quality and Innovation
RT	Robert Toole	ICMC	Infection Control Management Committee	EMSA	Eliminating Mixed Sex Accommodation
CW	Cherry West	CQRM	Clinical Quality Review Meeting	ESR	Electronic Staff Record
		PEWG	Patient Experience Working Group	HSDU	Hospital Sterilisation and Decontamination Unit
		PSWG	Patient Safety Working Group	HNU	Head and Neck Unit
		SMT	Senior Managers Team	IQP	Improving Quality Programme
		SPSSG	Staff & Patient Satisfaction Steering Group	LoS	Length of Stay
		SSCSG	Staff Satisfaction Campaign Steering Group	MHI	McKensie Hospital Institute
		SB	Sustainability Board	MSK	Musculoskeletal
		TC	Transformation Committee	PMO	Performance Management Office
		WSC	Workforce Strategy Committee	SHA	Strategic Health Authority
				SHIP	Southampton, Hampshire, IOW & Portsmouth
				SLAM	Service Level Agreement Manager
				SPB	Strategic Partnering Board

## Guidance for the Assessment of Risk Rating

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Highly likely (5)	5	10	15	20	25

<b>Green</b>	Low Risk (1 – 3)
<b>Yellow</b>	Moderate Risk (4 – 6)
<b>Amber</b>	High Risk (8 – 12)
<b>Red</b>	Extreme Risk (15 – 25)

Levels of Severity of Patient Safety Indicators	
<b>None</b>	A situation where no harm occurred: either a Prevented Patient Safety Incident or a No Harm Patient Safety Incident.
<b>Low</b>	Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm to one or more persons.
<b>Moderate</b>	Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons.
<b>Severe</b>	Any unexpected or unintended incident which caused permanent or long term harm to one or more persons.
<b>Death</b>	Any unexpected or unintended incident which caused the death of one or more persons.